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Supreme Court of the United States

October Term, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS AND BLUE SHIELD PLANS AND EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

(For Continuation Of Caption See Reverse Side Of Cover)

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF FOR THE STATES OF MINNESOTA, CONNECTICUT, MARYLAND, ILLINOIS, INDIANA, MASSACHUSETTS, MISSOURI, MONTANA, PENNSYLVANIA, TEXAS, WEST VIRGINIA AND WYOMING AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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Respondents.

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vs.

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TABLE OF CONTENTS

Page

STATEMENT OF INTEREST 1

SUMMARY OF ARGUMENT..... 3

ARGUMENT 4

I. THE SECOND CIRCUIT'S INDIRECT ECONOMIC IMPACT STANDARD FOR ERISA PREEMPTION SHOULD BE REJECTED IN FAVOR OF A MORE BALANCED TEST THAT BETTER REFLECTS THE PURPOSE OF ERISA PREEMPTION 4

A. The Indirect Economic Impact Standard Is Contrary To The Purpose Of ERISA Preemption Intended By Congress 4

1. The purpose of ERISA preemption was to facilitate operation of multi-state ERISA plans, not to exempt them from ordinary costs of doing business..... 6

2. The *Travelers* indirect economic impact standard threatens hospital rate-setting and other state health care measures that Congress specifically authorized 7

B. The Court's Precedent Supports A More Balanced ERISA Preemption Inquiry That Does Not Focus On Economic Impact Alone..... 11

C. The *Travelers* Economic Impact Standard Has Already Been Extended To Further Curtail Legitimate State Regulation..... 13

TABLE OF CONTENTS – Continued

Page

II. THE *TRAVELERS* INDIRECT ECONOMIC IMPACT STANDARD WILL PRESENT A MAJOR IMPEDIMENT TO STATE REGULATION IN THE HEALTH CARE ARENA AND ELSEWHERE 16

A. States Have An Enormous Financial And Social Stake In Their Health Care Systems That Cannot Be Addressed Without Some Impact On ERISA Plans 16

B. Preemption Under The *Travelers* Standard Threatens Substantial Amounts Of State Funding For Health Care Access, Much Of Which Is Generated Through Taxes Authorized By Federal Law 18

C. Even State Health Care Laws With A *De Minimis* Effect On ERISA Plans May Be Preempted Under *Travelers* 24

D. The Indirect Economic Impact Standard Is Likely To Affect Other Areas Of State Regulation 26

E. Should The Court Reach A Decision In This Case That The Surcharges Are Preempted Or Are Otherwise Inappropriate, Such Decision Should Not Extend Beyond The Facts Of The Case 27

CONCLUSION 29

TABLE OF AUTHORITIES

Page

FEDERAL DECISIONS

Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981) 29

Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc., 947 F.2d 1341 (8th Cir. 1991), cert. denied, 112 S. Ct. 2305 (1992) 13

Boyle v. Anderson, 849 F. Supp. 1307 (D. Minn.), appeal pending, No. 94-2237 (8th Cir. 1994) .. 13, 22, 25

FMC Corp. v. Holliday, 498 U.S. 52 (1990) 11

Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. 1 (1987) 7, 11, 29

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990) 6, 12, 14

Jordan v. Reliable Life Ins. Co., 694 F. Supp. 822 (N.D. Ala. 1988) 2

Mackey v. Lanier Collection Agency & Service, Inc., 486 U.S. 825 (1988) 11, 12, 14

Metropolitan Life Ins. Co., Inc. v. Massachusetts, 471 U.S. 724 (1985) 22, 29

New England Health Care Employees Union v. Mount Sinai Hospital, 846 F. Supp. 190 (D. Conn.), appeal pending, Nos. 94-7264 and 94-7906 (2d Cir. 1994) 10, 13, 14, 21

NYSA-ILA Medical and Clinical Services Fund v. Axelrod, 27 F.3d 823 (2d Cir. 1994) 14, 15, 24, 26

NYSA-ILA Medical and Clinical Services Fund v. Axelrod, No. 92 Civ. 2779, 1993 WL 51146 (S.D.N.Y. Feb. 23, 1993) 15

TABLE OF AUTHORITIES – Continued

Page

Rebaldo v. Cuomo, 749 F.2d 133 (2d. Cir. 1984), cert. denied, 472 U.S. 1008 (1985) 9

Standard Oil Co. v. Agsalud, 633 F.2d 760 (9th Cir. 1980), cert. denied, 454 U.S. 801 (1981) 17

The Health Maintenance Organization of New Jersey v. Whitman, No. 93-5775, 1994 WL 549626 (D.N.J. Oct. 3, 1994) 23

The Travelers Insurance Co. v. Cuomo, 14 F.3d 708 (2d Cir. 1994) ..... *passim*

Travelers Ins. Co. v. Cuomo, 813 F. Supp. 996 (S.D.N.Y. 1993) 8

United Wire, Metal & Machine Health and Welfare Fund v. Morristown Memorial Hospital, 995 F.2d 1179 (3d Cir.), cert. denied, 114 S. Ct. 382 (1993) 12, 13, 23, 25

FEDERAL STATUTES

42 U.S.C. § 1395ww(c)(1) 8

42 U.S.C. §§ 1396(a)(13), 1396r-4 10

42 U.S.C. § 1395f(b) 9

42 U.S.C. § 1395ww(c)(1)(A) 8

42 U.S.C. § 1395ww(c)(1)(B) 9

42 U.S.C. § 1396a(t) 10

42 U.S.C. § 1396b(w) 10

TABLE OF AUTHORITIES – Continued

Page

STATE STATUTES

Act of May 24, 1993, ch. 345, 1993 Minn. Laws 1535 22

Ala. Code § 22-6-30 19

Ark. Code Ann. §§ 26-52-1401 to -1406 (Michie Supp. 1993) 19

Cal. Health and Safety Code § 1254 (Deering Supp. 1994) 24

Cal. Health and Safety Code § 25015 et seq. (West Supp. 1994) 24

D.C. Code Ann. §§ 47-1221 to -1232 (Supp. 1994) 19

Fla. Stat. Ann. § 381.0098, et seq. (1993 and Supp. 1994)..... 25

Fla. Stat. Ann. § 395.7015 (West 1994)..... 19

Haw. Rev. Stat. §§ 346E-1 to -16 (Supp. November 1993)..... 19

HealthRight Act, ch. 549, 1992 Minn. Laws 1487 22

Ill. Ann. Stat. ch. 210, para. 85/1 et seq. (1993) 24

Ill. Ann. Stat. ch. 305, para. 35-1/2 (Smith-Hurd Supp. 1994) 19

Ky. Rev. Stat. Ann. §§ 142.301, 142.303, 142.307, 142.311..... 19

Mass. Gen. L. ch. 118F, § 15 (1990 ed.)..... 19

Me. Rev. Stat. Ann. tit. 22, §§ 396-F to 396-I (West 1992)..... 19

Minn. Stat. 256.9657, subds. 1 and 2 (1992 and Supp. 1993) 19

TABLE OF AUTHORITIES – Continued

Page

Minn. Stat. § 295.52 (1992) 22

Miss. Code Ann. § 43-13-141 et seq. (1972) 19

Mo. Ann. Stat. § 208.453 (Vernon Supp. 1994) 20

Mont. Code Ann. § 15-60-102 20

N.H. Rev. Stat. Ann. § 84-A:1 to -A:12 (Supp. 1993) 20

N.Y. Public Health Law § 2807-a(23) to (27) (McKinney 1994) 20

Nev. Rev. Stat. § 422.383 20

R.I. Gen. Laws § 23-19.12-1 et seq. (Supp 1993) 25

S.C. Code Ann. § 44-7-250 (Law. Co-op. Supp. 1993) 24

S.C. Code Ann. § 44-93-10 et seq. (Law. Co-op. Supp. 1993) 25

S.C. Code Ann. § 12-23-810 et seq. (Supp. 1994) 20

Utah Code Ann. § 26-36-101 et seq. (Supp. 1994) 20

Vt. Stat. Ann. tit. 33, §§ 1950-1958 20

W. Va. Code §§ 11-27-1 to -35 (Supp. 1994) 20

Wash. Rev. Code Ann. § 82.65A.010 (West Supp. 1994) 20

OTHER AUTHORITIES

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TABLE OF AUTHORITIES – Continued

Page

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Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. Davis L. Rev. 255 (1990) 2

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Health Systems Review, Vol. 27, No. 5, September/October 1994 18

H.R. Rep. No. 102-310, 102d Cong., 1st Sess. 3 (1991), *reprinted in* 1991 U.S.C.C.A.N. 1413 18

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Human Resources Div., U.S. General Accounting Office, *Health Insurance Regulation* (Dec. 1993) 22

Fernando R. LaGuarda, Note, Federalism Myth: States as Laboratories of Health Care Reform, 82 Geo. L.J. 159 16

TABLE OF AUTHORITIES – Continued

Page

Robert Pear, *Health Changes as Congress Fails*, N.Y. Times, September 16, 1994 at A1, A22 16

Prospective Payment Assessment Comm'n, *Analysis of Medicaid Disproportionate Share Payment Adjustments* (Jan. 1994) 17

STATEMENT OF INTEREST

The amici curiae states, through their attorneys general, respectfully submit this brief in support of Petitioners. Amici support reversal of the decision of the Second Circuit Court of Appeals holding that New York's hospital rate surcharges are preempted by ERISA.

The amici states have a strong interest in the ERISA preemption issues presented by this case. The states have an interest in assuring that the scope of ERISA preemption is maintained within the ambit of congressional purpose and that the states' remaining sphere of regulatory power is not improperly undermined. Although the language of the ERISA preemption provision is broad, Congress did not intend to preclude all state regulation that indirectly has an economic effect on ERISA plans, as the Second Circuit has held.

On a more specific level, the amici states have a critical interest in this case because the Second Circuit's ruling significantly impinges on their ability to implement legislative solutions in an area of traditional state power, the regulation of health care. States have played a long-standing role in both the overall regulation of the health care system and the provision of health care to the indigent. The extensive public debate on health care of the past two years has made well-known the enormous and challenging tasks of containing skyrocketing costs and at the same time providing adequate, quality care to all those in need.

The states cannot afford to leave these issues unaddressed. As pointed out by the GAO:

> State governments have a major stake in financing and providing health care. States are concerned about the growing proportion of their

> budgets devoted to health – they already spend an average of 20 percent of their total budgets on health-related programs. Yet in some states, almost one-quarter of the population is uninsured.

Human Resources Div., U.S. General Accounting Office, *Access to Health Care, States Respond to Growing Crisis* 2 (June 1992).

It is widely recognized that ERISA preemption serves as a major obstacle to many of the reforms that states would like to enact to address these pressing issues of health care cost containment and the expansion of access to health care. *See, e.g., id.;* Patricia A. Butler, National Governors Ass'n, *Roadblock to Reform, ERISA Implications for State Health Care Initiatives* (1994); Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured,* 24 U.C. Davis L. Rev. 255 (1990); Vicki Gottlich, *ERISA Preemption: A Stumbling Block to State Health Care Reform,* Clearinghouse Review 1469 (March 1993).

The Second Circuit's adoption of an indirect economic impact basis for ERISA preemption is thus of great concern to the amici states because it is a significant expansion of already broad ERISA preemption. The approach to ERISA preemption embraced in this case and its progeny threatens effectively to block appropriate state regulation in the health care area. ERISA preemption has in the past been referred to as a quicksand. *Jordan v. Reliable Life Ins. Co.,* 694 F. Supp. 822, 827 (N.D. Ala. 1988). The amici states fear that unless the decision below is reversed, the application of the indirect economic impact standard will necessarily intensify the force of ERISA preemption, and the states will be faced not with a quicksand, but with an inescapable black hole.

SUMMARY OF ARGUMENT

The Second Circuit Court of Appeals erroneously concluded that the indirect economic effect of state statutes on ERISA plans, in and of itself, is sufficient to preempt operation of state statutes, in this case surcharges on amounts charged for hospital services. This simplistic test is contrary to Congress' intent in enacting the ERISA preemption provisions. Consistent with the Commerce Clause authority under which ERISA itself was enacted, the core purpose of ERISA preemption is to enable ERISA plans to operate on a multi-state basis, without interference by a patchwork of differing state regulation. Congress did not intend for ERISA to preempt traditional areas of state concern, such as hospital rate-setting and regulation of health care, where they have no impact on interstate operation of ERISA plans. Federal law enacted subsequent to ERISA specifically approves of states establishing their own hospital reimbursement systems and authorizes the establishment of health care-related taxes by the states to generate income that will then be redistributed back to the hospitals. The Second Circuit's expansive approach to ERISA preemption threatens the very measures enacted by states pursuant to these congressional authorizations.

The Court should reject the narrowly-focused economic impact standard of Travelers in favor of an inquiry that includes the factors this Court has employed. This analysis should examine whether the state law singles out ERISA plans for different treatment and whether the state law dictates the manner in which ERISA plans structure themselves or conduct their business, all factors that bear on the recognized core purpose of ERISA preemption.

The states are in serious jeopardy of being forced to abdicate responsibilities and powers to regulate health care if the *Travelers* standard is upheld. With health care

reform now squarely up to the states, it is critical that states have flexibility to establish new programs to spread the burden of uncompensated care experienced by hospitals and to improve access to health care for uninsured individuals.

Many states rely on congressionally-approved health care-related taxes to reimburse hospitals for the uncompensated care they provide to low-income patients and to take advantage of millions of dollars of matching federal revenue available through the Medicaid program. Under *Travelers*, however, these state taxes are in danger of being preempted.

The quality of health care is also at risk if *Travelers* is upheld. State laws that ensure proper sanitary conditions and adequate patient/nurse ratios in hospitals may increase hospital charges to patients. Even these laws, therefore, may be invalidated under the indirect economic impact test in *Travelers*.

The Second Circuit's indirect economic impact standard is a significant expansion of an already broad preemption provision. Congressional intent and principles of federalism that govern preemption analysis require that this expansion be rejected.

ARGUMENT

I. THE SECOND CIRCUIT'S INDIRECT ECONOMIC IMPACT STANDARD FOR ERISA PREEMPTION SHOULD BE REJECTED IN FAVOR OF A MORE BALANCED TEST THAT BETTER REFLECTS THE PURPOSE OF ERISA PREEMPTION.

A. The Indirect Economic Impact Standard Is Contrary To The Purpose Of ERISA Preemption Intended By Congress.

In the decision below, *The Travelers Insurance Co. v. Cuomo*, 14 F.3d 708 (2d Cir. 1994) ("*Travelers*"), the Second

Circuit held that mere indirect economic impact alone, such as that which results from the purchase of goods or services by an ERISA plan, is enough to trigger ERISA preemption of state laws. It is this central holding that is of primary concern to the amici states and to which this amicus brief is addressed.

In *Travelers*, three state-imposed surcharges on hospital rates were challenged by plaintiffs consisting of commercial health insurers and a trade association of such insurers. The Second Circuit held that the surcharges are preempted under ERISA because they "force the ERISA plans to either increase plan costs or reduce plan benefits." *Travelers*, 14 F.3d at 720-21 (footnote omitted). The court reasoned that because the surcharges imposed a significant economic burden on commercial insurers and HMOs, "[t]hey therefore ha[d] an impermissible impact on ERISA plan structure and administration." *Id.*

Thus, the court ruled that any state regulation that significantly increases the costs incurred by an ERISA health benefit plan, whether directly or indirectly, is preempted. No inquiry is necessary under the Second Circuit's standard to determine whether or how the structure or administration of the ERISA plan will be affected, because an impermissible effect is presumed from the the economic impact itself. No inquiry is necessary into the effect on the multi-state operation of the plan. Increased cost to the plan is enough.

This indirect economic impact standard for ERISA preemption embraces an analysis that permits state law to be preempted based on a superficial finding of connection with ERISA plans. The approach is flawed because it fails to consider the real purpose for which Congress enacted the ERISA preemption provision and ignores the fact that some of the very regulations that are being

invalidated have been authorized and encouraged by Congress in other statutes.

1. The purpose of ERISA preemption was to facilitate operation of multi-state ERISA plans, not to exempt them from ordinary costs of doing business.

The Second Circuit's indirect economic impact standard bears no relationship to the purpose of the ERISA preemption provision repeatedly identified by this Court. Congress did not intend to create a charmed existence for ERISA plans that would exempt them from any state regulation that increases the cost of goods and services they purchase. Rather, the ERISA preemption provision was meant to preserve the ability of ERISA plans to function on a multi-state basis. As the Court recently explained:

> Section 514(a) [the ERISA preemption provision] was intended to ensure that plans and plan sponsors would be subject to a *uniform body of benefit law;* the goal was to minimize the administrative and financial burden of complying with *conflicting directives* among States or between States and the Federal Government.

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990) (citations omitted; emphasis added). Clearly, the core congressional purpose was to avoid a patchwork of differing state regulation that would interfere with efficient multi-state administration of ERISA benefit plans. This concern for the ability of multi-state ERISA plans to operate free of conflicting state regulation is consistent with the Commerce Clause authority under which ERISA was enacted. Preemption based on indirect economic impact does not further that purpose.

Given this repeatedly-acknowledged goal of ERISA preemption, the proper inquiry is whether the challenged

state regulation will interfere with the goal of uniformity. In upholding a Maine statute against an ERISA preemption challenge, the Court used precisely that analysis:

> The Maine statute therefore creates no impediment to an employer's adoption of a uniform benefit administration scheme. Neither the possibility of a one-time payment in the future, nor the act of making such a payment, in any way creates the potential for the type of conflicting regulation of benefit plans that ERISA preemption was intended to prevent. As a result, pre-emption of the Maine law would not serve the purpose for which ERISA's preemption provision was enacted.

Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. 1, 14-15 (1987) (footnote omitted).[1] The Second Circuit ignores this crucial inquiry about the potential for conflicting regulation and substitutes a simplistic test of increased cost that has no basis in congressional intent.

2. The *Travelers* indirect economic impact standard threatens hospital rate-setting and other state health care measures that Congress specifically authorized.

Congress, as evidenced in the Medicare and Medicaid programs, contemplated the existence of state health

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[1] Although ERISA preemption was intended to prevent conflicting state regulation of ERISA plans, the purpose was not to require uniformity in the sense that all hospital payment rates must be the same in every state. They were not when ERISA was enacted, and they are not now. For example, charges per case in 1974 varied from $494 in Wyoming to $1356 in New York. American Hospital Association, *Hospital Statistics* (1975 ed.). Similarly, in 1992, charges per case ranged from $3807 in Mississippi to $8218 in the District of Columbia. American Hospital Association, *Hospital Statistics* (1993-94 ed.).

care regulation, both to contain hospital costs and to ensure access to health care for low-income people. Another indication that the Second Circuit has carried ERISA preemption beyond the bounds Congress intended is that these state measures, specifically envisioned by federal law enacted subsequent to ERISA, cannot survive the *Travelers* indirect economic impact standard.[2]

The federal Medicare statute, 42 U.S.C. § 1395ww(c)(1), enacted in 1983, expressly gives the Secretary of the United States Department of Health and Human Services ("Secretary") discretion to reimburse hospitals "in accordance with a hospital reimbursement control system in a State" – a provision specifically designed to encourage states to enact cost containment measures in the field of hospital care. One of the conditions a state system must meet is that the state-established rates must be applicable to at least 75% of all revenues or expenses in the particular state for inpatient hospital services. 42 U.S.C. § 1395ww(c)(1)(A). Thus, the general authority given states to establish hospital cost containment systems is inconsistent with a broad-based ERISA exclusion. Indeed, if charges to ERISA plans or their insurers are excluded from hospital rate-setting, it is difficult to see how the 75% minimum target could be achieved.

Another condition for an all-payor state hospital rate system to qualify for Medicare reimbursement is that the state must provide "satisfactory assurances as to the *equitable treatment* under the system of all entities (including

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[2] The district court *Travelers* decision acknowledged that its ruling would mean the demise of states' efforts to regulate and control hospital costs. *See Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996, 1006 (S.D.N.Y. 1993).

federal and state programs) that pay hospitals for inpatient hospital services, of hospital employees, and of hospital patients." 42 U.S.C. § 1395ww(c)(1)(B) (emphasis added). It is not reasonable to believe that Congress would have required equity among all payors of hospital charges in the Medicare law, while simultaneously intending to insulate ERISA plans from the reach of hospital rate-setting.

Finally, under provisions enacted in 1983 and most recently amended in 1990, Congress has waived standard Medicare principles of reimbursement in favor of a state's reimbursement system, provided the state system meets a performance test and also provided that not only Medicare, but all third party payors, reimburse hospitals in the particular state on the basis of that state's system.[3] 42 U.S.C. § 1395f(b). Nothing in this legislation even remotely suggests that the term "payors" was intended to exclude ERISA plans.

Therefore, states that engage in hospital rate-setting consistent with authority conferred by federal law are effectuating the intent of Congress. Congress clearly did not intend an ERISA preemption standard of indirect economic impact that strikes down those same rate-setting systems. As Judge Van Graafeiland commented in *Rebaldo v. Cuomo*, 749 F.2d 133, 140 (2d. Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985): "When Congress gives authority with one hand, it ordinarily does not take it away with the other hand."

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[3] Maryland is one state with a genuinely "all-payor" system. All payors pay hospitals on the basis of the state's system. Maryland has retained its Medicare waiver since 1977 without interruption. Other states that have been granted waivers in the past have included Massachusetts, New Jersey, and New York, although these waivers are no longer in effect.

Similarly, federal Medicaid law specifically authorizes states to impose health care-related taxes that are jeopardized by the expanded scope of ERISA preemption adopted in *Travelers*. As part of its 1991 amendments to the federal Medicaid Act, Congress explicitly authorized states to use taxes of general applicability, such as a sales tax extended to hospital charges, 42 U.S.C. § 1396a(t), and health care provider taxes, 42 U.S.C. § 1396b(w), as a means of raising revenue that qualifies for federal matching funds, and which can be redistributed to hospitals to reimburse them for care they provide to low-income patients. 42 U.S.C. §§ 1396(a)(13), 1396r-4.

Like the Medicare hospital rate-setting authorization, Medicaid authorization of these taxes, which requires that they be broad-based and uniform, is directly inconsistent with an economic impact standard for ERISA preemption that would preclude those taxes from being applied in the manner required by Congress. Nevertheless, these very taxes that Congress has granted states authority to impose have already been held to be preempted in reliance upon the *Travelers* analysis. *See New England Health Care Employees Union v. Mount Sinai Hospital*, 846 F. Supp. 190 (D. Conn.), *appeal pending*, Nos. 94-7264 and 94-7906 (2d Cir. 1994) (hereinafter *"New England Health Care"*). Using the *Travelers* analysis, the district court decided that the Connecticut statute was preempted by ERISA because the uniform sales tax and provider taxes had a substantial economic impact on ERISA plans and because a large percentage of the revenue generated came from ERISA plans. Therefore, the state's taxes were preempted, despite the fact that they were specifically authorized by Congress and despite, indeed because of, the fact that they were applied uniformly to all patients and all hospital revenues as required by Congress.

The Second Circuit's indirect economic impact standard is in conflict with congressional intent to encourage states to enact hospital rate-setting laws and uniformly-applied health care-related taxes. It should, therefore, be rejected.

B. The Court's Precedent Supports A More Balanced ERISA Preemption Inquiry That Does Not Focus On Economic Impact Alone.

The Second Circuit's willingness to rest a determination of ERISA preemption on indirect economic impact alone is also contrary to the teaching of this Court. The Court has consistently relied on other factors that enable it to assess the impact of the challenged state law on the congressional goal of unimpeded interstate operation of ERISA plans, rather than the narrow focus on economic impact utilized in *Travelers*.

In *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), the Court rejected an ERISA challenge to Georgia garnishment laws despite claims of substantial economic impact. *Id.* at 831; *see also id.* at 842 (Kennedy, J., dissenting). Not only did the Court refuse to find preemption in *Mackey* despite significant economic impact, none of the decisions in which the Court has found ERISA preemption is based on economic impact alone.

Instead, the Court has relied on factors that reflect congressional intent that states not impede multi-state operation of ERISA plans. Thus, in *Fort Halifax Packing Co.*, the Court explicitly addressed lack of impact of the Maine law on multi-state operations. 482 U.S. at 8-14. In *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990), the Court found that the state antisubrogation law would affect the structure of the plan and the administration of benefits in a way that would impair multi-state operation. In other

cases, the Court has found preemption where the challenged law made specific reference to ERISA plans or was premised on their existence. *See Mackey*, 498 U.S. at 830 (express exception for ERISA plans from garnishment law preempted); *Ingersoll-Rand*, 498 U.S. at 140 (cause of action for unlawful discharge to defeat ERISA benefits claim preempted because premised on existence of ERISA plan). State statutes that single out ERISA plans for differential treatment are likely to defeat the goal of unimpeded multi-state operation that Congress sought.

ERISA preemption analysis should reflect these factors used by this Court, rather than the narrow economic impact focus of the Second Circuit. The Third Circuit in *United Wire, Metal & Machine Health and Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179, 1994 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993), used a balanced approach that assesses the impact in a manner more suited to the purpose of ERISA preemption and is more consonant with this Court's decisions. Echoing the language of *Ingersoll-Rand*, 498 U.S. at 139-40, the Third Circuit described the statute before it in a manner that articulated the proper factors for assessing ERISA preemption:

> In summary, we, too, have before us a generally applicable law which (1) is not intended to regulate the affairs of ERISA plans, (2) neither singles out such plans for special treatment nor predicates rights or obligations on the existence of an ERISA plan, and (3) does not have either the effect of dictating or restricting the manner in which ERISA plans structure or conduct their affairs or the effect of impairing their ability to operate simultaneously in more than one state.

United Wire, 995 F.2d at 1195.[4] These criteria soundly evaluate the impact of state regulation on ERISA plans and ensure the proper freedom from state interference while preserving the state's permissible role.

C. The Travelers Economic Impact Standard Has Already Been Extended To Further Curtail Legitimate State Regulation.

In assessing the impact of the *Travelers* economic impact standard, the Court has the benefit of two subsequent cases that follow and expand on the *Travelers* ruling. Thus, it is not necessary to rely on conjecture about where the Second Circuit's path will lead.

Following on the heels of *Travelers*, the federal district court in Connecticut adjudicated an ERISA preemption challenge to a six percent sales tax on hospital services and an additional assessment on hospital revenues for patient care services, both of which complied with federal Medicaid law because they were applied uniformly to all patients and to hospital revenue from all services. *New England Health Care Employees Union v. Mount Sinai Hospital*, 846 F. Supp. 190 (D. Conn.), *appeal pending*, Nos. 94-7264 and 94-7906 (2d Cir. 1994). The taxes were used to fund a pool from which hospitals were compensated for the cost of providing care to those unable to pay. The court reiterated the *Travelers* conclusion that economic impact on ERISA plans that could

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[4] Alternatively, the similar multi-factor analysis employed by the Eighth Circuit would be preferable to the singular indirect economic impact standard. *See Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d 1341 (8th Cir. 1991), *cert. denied*, 112 S. Ct. 2305 (1992); *see also Boyle v. Anderson*, 849 F. Supp. 1307 (D. Minn.), *appeal pending*, No. 94-2237 (8th Cir. 1994).

require the plans to either increase costs or reduce benefits "almost by definition" has an effect on the structure and administration of the plans that warrants preemption. *Id.* at 197.

Moreover, the court in *New England Health Care* expanded the scope of ERISA preemption even further. In addition to the *Travelers* indirect economic impact rationale, the court based its preemption ruling on the ground that the Connecticut law "depends on ERISA plans to accomplish its purpose." *Id.* at 195. This fatal dependence was established merely by the fact that, according to the court, 70% of the revenues generated by the law would come from ERISA plans.

The Second Circuit adopted a similar approach in another post-*Travelers* case, *NYSA-ILA Medical and Clinical Services Fund v. Axelrod*, 27 F.3d 823 (2d Cir. 1994) (hereinafter *"NYSA-ILA"*). In that case, the Second Circuit ruled that a New York hospital gross receipts tax (the Health Facilities Assessment or "HFA") was preempted because the tax was directed only at the health care industry. The court stated: "Because this industry is, by definition, the realm where ERISA welfare plans must operate, the HFA was bound to affect them." *Id.* at 827. On this basis, the court ruled that the HFA was not a law of general application, distinguishing it from laws that apply to ERISA plans and to all other segments of society as well. The Second Circuit implicitly declined to follow this Court's approach that examines whether the law is one of general applicability or whether it specifically refers to or is premised on the existence of ERISA plans. *See Mackey*, 486 U.S. at 830; *Ingersoll-Rand*, 498 U.S. at 140.

Although couched in different language, this rationale in *NYSA-ILA* is premised on the same foundation as the "dependence on ERISA plans" reasoning in *New England Health Care*. Essentially, these courts have held that

because a significant percentage of the benefits in the health care field are provided through ERISA plans, state regulation in that field is preempted because it either "necessarily affects" those plans or is dependent on them for its success. No decision of this Court has taken ERISA preemption to that extreme, nor should it.

The Second Circuit in *NYSA-ILA* also expanded the reach of its *Travelers* economic impact approach. In *Travelers*, the court held that a "substantial" economic impact would result in preemption. In *NYSA-ILA*, the court held that in some circumstances, the impact need not even be substantial. The tax at issue in *NYSA-ILA* was only 0.6%, imposed on hospital gross receipts. The district court held this did not create a substantial economic impact warranting preemption:

> The impacts on benefit plans are incidentally economic resulting only in the need for administrative and accounting procedures to comply with the law.
>
> The fact that the tax will leave less money for benefits is not decisive here. . . . The tax is not great enough to pose a serious economic threat to the plan which might trigger preemption.

NYSA-ILA Medical and Clinical Services Fund v. Axelrod, No. 92 Civ. 2779, 1993 WL 51146, at *4 (S.D.N.Y. Feb. 23, 1993).

Reversing the district court, the Second Circuit ruled that "[a] statute that 'relates to' ERISA plans cannot escape preemption simply because the magnitude of the impact is thought to be insubstantial." *NYSA-ILA*, 27 F.3d at 828. The court apparently found the requisite connection between the state law and ERISA plans based on two factors. First, the tax was imposed only on the health care industry. *Id.* at 827. Second, the plaintiff plan actually operated medical centers that were directly subject to the

tax. If the first factor, by itself, is sufficient to eliminate the substantiality requirement for economic impact preemption, any state regulation in the health care field that incidentally imposes any additional cost on an ERISA plan would be preempted. Alternatively, if the second factor is enough to warrant preemption, hospitals and other health care facilities owned by ERISA plans would be insulated from the broad range of state economic, professional and safety regulation to which such facilities are now subject. See p. 26, *infra*.

II. THE *TRAVELERS* INDIRECT ECONOMIC IMPACT STANDARD WILL PRESENT A MAJOR IMPEDIMENT TO STATE REGULATION IN THE HEALTH CARE ARENA AND ELSEWHERE.

A. States Have An Enormous Financial And Social Stake In Their Health Care Systems That Cannot Be Addressed Without Some Impact On ERISA Plans.

The responsibility for regulating health care and ensuring that health care services remain available and affordable to everyone in need of them continues to rest with the states. Congress has not enacted substantial national health care reform. Therefore, the states have devised means to increase access to health care for their uninsured and underinsured populations.[5]

States have a crucial stake in the success of these efforts. States spent about $100 billion on health care in 1991. Fernando R. LaGuarda, Note, *Federalism Myth: States as Laboratories of Health Care Reform*, 82 Geo. L.J. 159, 170 n.62 (citing Congressional Budget Office, *Economic Implications of Rising Health Care Costs* 7 (1992)). As

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[5] Robert Pear, *Health Changes as Congress Fails*, N.Y. Times, September 16, 1994 at A1, A22.

noted at p. 1, *supra*, states spend an average of 20 percent of their budgets on health-related programs. Despite these enormous expenditures, many people remain uninsured. See n.12, *infra*. Moreover, costs continue to escalate. For example, from 1990 to 1993, state Medicaid program spending for in-patient hospital services grew from $17.4 billion to $40.4 billion. Prospective Payment Assessment Comm'n, *Analysis of Medicaid Disproportionate Share Payment Adjustments* 2 (Jan. 1994).

When states attempt to contain the costs of or assure fair access to health care, they are faced with the increasingly formidable hurdle of ERISA preemption. The ERISA preemption clause has properly been interpreted to prohibit state laws that require employers to offer health insurance or specific health benefits to their employees or to pay a portion of health care insurance premiums. *See, e.g., Standard Oil Co. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *cert. denied*, 454 U.S. 801 (1981). Even when ERISA preemption is limited to its proper boundaries, it is a significant obstacle to effective state action in the health care area. See citations at p. 2, *supra*. When courts give ERISA preemption an overly expansive scope, as in *Travelers*, it can make the states' task an impossibility.

The reality facing states as they try to keep health care accessible and affordable is that most people in the United States obtain health care benefits through their employment or the employment of a family member.[6] The Second Circuit in *Travelers* stated that 88% of "non-elderly

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[6] According to the Employee Benefit Research Institute, 62.5% of the non-elderly population have employment-based health insurance coverage. Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured – Analysis of the March 1993 Current Population Survey*, EBRI Issue Brief Number 145 at 1 (January, 1994) (hereinafter "*EBRI Issue Brief*").

Americans have private health insurance through their employee welfare benefit plans."[7] *Travelers*, 14 F.3d at 711. It is also true that most of these employee benefit plans are governed by ERISA.[8] If state laws in the health care field are preempted simply because they affect ERISA plan participants along with all other citizens of a state, no state health care law will survive ERISA preemption. So sweeping a result was not what Congress intended in enacting ERISA, nor what this Court envisioned in its decisions construing the ERISA preemption clause.

B. Preemption Under The *Travelers* Standard Threatens Substantial Amounts Of State Funding For Health Care Access, Much Of Which Is Generated Through Taxes Authorized By Federal Law.

Approximately half of the states have enacted taxes on health care provider revenues in accordance with federal Medicaid law.[9] These states acted for the dual

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[7] It is likely that the court meant that 88% of the non-elderly *who have* private health insurance have it through employee plans.

[8] With certain limited exceptions, all private employers that offer health insurance benefits to their employees are governed by ERISA.

[9] As of September 15, 1991, 27 states used revenues from health care provider taxes, typically based on a percentage of the revenues paid to providers, to help fund their Medicaid programs. *See* H.R. Rep. No. 102-310, 102d Cong., 1st Sess. 3 (1991), *reprinted in* 1991 U.S.C.C.A.N. 1413, 1416. Based on data received from the Department of Health and Human Services, Health Care Financing Administration, and the 1994 State Legislative Survey conducted by the Federation of American Health Systems and published in *Health Systems Review*, Vol. 27, No. 5, September/October 1994, approximately the same number of states continue to use some form of a health care-related tax as a

purpose of increasing access to health care services for low-income people and obtaining matching federal revenue

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vehicle for funding payments to hospitals for the uncompensated care they provide to low-income people and obtaining matching federal revenue for their states. *See, e.g.*, Ala. Code § 22-6-30 (taxes levied on providers of medical services); Ark. Code Ann. §§ 26-52-1401 to -1406 (Michie Supp. 1993) (6% tax on total gross receipts derived from all personal care services provided by a personal care services provider; 2.8% tax on total gross receipts derived by long-term care facilities or nursing facilities; 4.78% on total gross receipts derived by intermediate care facilities for the mentally retarded); D.C. Code Ann. §§ 47-1221 to -1232 (Supp. 1994) (1.5% assessment on hospitals, assessment equal to $11.88 per patient day on nursing homes, assessment equal to $15.29 per patient day on intermediate care facilities for the mentally retarded); Fla. Stat. Ann. § 395.7015 (West 1993) (1.5% assessment on annual net operating revenue for certain health care entities); Haw. Rev. Stat. §§ 346E-1 to -16 (Supp. November 1993) (4% assessment on all hospital income, 6% assessment on all nursing facility income); Ill. Ann. Stat. ch. 305, para. 35-1/2 (Smith-Hurd Supp. 1994) (assessments on hospital, nursing homes and intermediate care facilities for the mentally retarded); Ky. Rev. Stat. Ann. §§ 142.301, 142.303, 142.307, 142.311 (2.5% tax on gross revenues of hospitals; 2% tax on gross revenues of nursing facilities, intermediate care facilities for the mentally retarded, physician services, licensed home health care services and HMO services; $0.25 prescription tax on pharmacies or any other provider dispensing or delivering outpatient prescription drugs); Me. Rev. Stat. Ann. tit. 22, §§ 396-F to 396-I (West 1992) (hospitals transmit percentage of net patient service revenues to hospital payments fund from which payments are made to hospitals for uncompensated care costs); Mass. Gen. L. ch. 118F, § 15 (1990 ed.) (hospital assessments calculated by State Department of Medical Security); Minn. Stat. § 256.9657, subds. 1 and 2 (1992 and Supp. 1993) (assessment of 1.4% of net patient revenues on hospitals, assessment of $535 per licensed nursing home bed, 0.6% surcharge on health maintenance organization total premium revenues); Miss. Code Ann. § 43-13-141 *et seq.* (1972) (with amendments through 1993)

for payments made to hospitals to assist them with their uncompensated care costs. For the states that have enacted these taxes, as authorized by federal law, the ramifications of the *Travelers* decision are particularly disastrous.

As discussed at p. 10, *supra*, in order to qualify for matching federal funds, the state tax laws must apply uniformly to revenue received from all payors for services, except government benefit programs. These laws typically tax health care providers, such as hospitals,

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(assessments on nursing facilities and intermediate care facilities for the mentally retarded); Mo. Ann. Stat. § 208.453 (Vernon Supp. 1994) (hospitals pay a federal reimbursement allowance for the privilege of engaging in the business of providing inpatient health care in the state); Mont. Code Ann. § 15-60-102 (assessment of $2.00 per nursing facility bed day for fiscal year 1994 and $2.80 per bed day for fiscal year 1995); Nev. Rev. Stat. § 422.383 (tax on hospitals not to exceed 6% of the net revenue from in-patients); N.H. Rev. Stat. Ann. §§ 84-A:1 to -A:12 (Supp. 1993) (Medicaid Enhancement Tax on gross patient services revenue of every hospital to be established by legislation each biennium); N.Y. Public Health Law § 2807-a(23) to (27) (McKinney 1994) (assessments on hospitals' gross earnings for inpatient services pooled and redistributed); S.C. Code Ann. § 12-23-810 *et seq.* (Supp. 1994) (hospital tax based on total expenditures of each hospital as percentage of total hospital expenditures statewide); Utah Code Ann. § 26-36-101 *et seq.* (Supp. 1994) (Medicaid Hospital Provider Temporary Assessment imposed on each hospital, hospital-based ambulatory surgical facility, and free-standing ambulatory surgical facility); Vt. Stat. Ann. tit. 33, §§ 1950-1958 (assessment of 2% of gross inpatient revenues on hospitals, assessment of $725 per licensed nursing home bed, assessment of 6% of total direct and indirect expenses of intermediate care facilities for mentally retarded); Wash. Rev. Code Ann. § 82.65A.010 (West Supp. 1994) (tax on intermediate care facilities for the mentally retarded); W. Va. Code §§ 11-27-1 to -35 (Supp. 1994) (health care tax on wide variety of health care services and entities).

based on revenues they receive on behalf of patients. In order to comply with the "broad-based" and "uniform" requirements of the Medicaid law, the taxes are imposed irrespective of the patients' status as ERISA plan participants or beneficiaries. *See* n.9, *supra*.

The consequences of the *Travelers* indirect economic impact standard for states with these taxes are severe. ERISA preemption of these taxes will strike at the heart of states' ability to provide health care for those of limited means. For instance, nearly one-fifth of West Virginia's citizens are dependent upon Medicaid to provide essential health care services. Over one-third of West Virginia's total Medicaid revenues are generated by the collection of Health Care Provider Taxes imposed on hospitals and other institutions, as well as on physicians and other individual providers of health care services.[10] The provider tax on hospitals alone (plus associated federal match) funded nearly one-sixth of the State's Medicaid Program in Fiscal Year 1994. Thus, in excess of fifty thousand West Virginia residents (one-sixth of the active Medicaid-eligible population) are dependent on the provider tax on hospitals for essential health care services.

Nor is this threat hypothetical. The *New England Health Care* decision, which relied on the sweeping indirect economic impact test to strike down Connecticut's uncompensated care pool taxes, demonstrates the inevitable, expanding impact of the *Travelers* case on state health care measures. 846 F. Supp. at 197. As a result of the *New*

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[10] West Virginia, due to its low per capita income, enjoys a 3 to 1 federal match ratio. Thus, every dollar raised by its provider tax results in four dollars of funding for its Medicaid Program. Its provider tax revenues of approximately $106 million annually therefore support in excess of $425 million of its $1.24 billion Medicaid Program.

England Health Care decision, Connecticut is in jeopardy of losing approximately $150 million in matching federal funds. Other states that have enacted taxes in accordance with federal Medicaid law will also be forced to forfeit substantial amounts of federal dollars if their taxes are similarly preempted. For example, Massachusetts stands to lose $140-150 million; Vermont would lose approximately $23.1 million; and Montana is at risk of losing approximately $17 million.

In addition to Medicaid-related taxes, other state efforts to finance the cost of comprehensive health care reform will be hampered by an indirect economic impact test for ERISA preemption. For example, the Minnesota health care reform program is a multi-faceted approach that includes cost containment measures as well as a program to provide care to the uninsured. *See* Health-Right Act, ch. 549, 1992 Minn. Laws. 1487; Act of May 24, 1993, ch. 345, 1993 Minn. Laws 1535. It is funded in part by a 2% tax on gross receipts of health care providers. Minn. Stat. § 295.52 (1992). That tax is the subject of an ERISA preemption challenge by several self-insured ERISA plans.[11] *Boyle v. Anderson*, 849 F. Supp. 1307 (D.

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[11] Over half of all U.S. workers are covered by health plans that are self-insured. Human Resources Div., U.S. General Accounting Office, *Health Insurance Regulation* 5 (Dec. 1993). ERISA preemption has generally provided self-insured plans greater insulation from state regulation than insured plans. *See, e.g., Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). An indication of the expansive effect of the *Travelers* indirect economic impact standard is that the New York hospital surcharges were found preempted even though the plaintiffs are insurance companies and the impact at issue was necessarily therefore on insured ERISA plans. Nevertheless, the fact that there are no self-insured plans as plaintiffs in this action does not mean that self-insured plans are not subject to this Court's ERISA analysis. Nor does it mean that the indirect economic

Minn.), *appeal pending*, No. 94-2237 (8th Cir. 1994). The federal district court in Minnesota upheld the tax, rejecting an indirect economic impact argument based on *Travelers*. If this Court holds that indirect economic impact alone is sufficient to warrant preemption, the Minnesota provider tax will fall, as will the ability of all states to use one of the few mechanisms available for funding expansion of health care access.

Another example of a state health care law that would be jeopardized if the indirect economic impact standard is embraced by this Court is New Jersey's Health Insurance Reform Act, challenged in *The Health Maintenance Organization of New Jersey v. Whitman*, No. 93-5775, 1994 WL 549626 (D.N.J. Oct. 3, 1994). The New Jersey legislature found that a number of commercial health insurers were not issuing individual policies because they tended to cover poor risks. The result was that Blue Cross and Blue Shield, with state-mandated open enrollment, were incurring extensive losses. The Act was intended to distribute those losses more equitably among all health insurance carriers in the state. The Act imposes an assessment, based on annual premiums, on all health insurance carriers. An exemption from the assessment is available for carriers who agree to write a certain number of individual policies on an open enrollment basis. An HMO subject to the assessment challenged the Act on ERISA preemption grounds. The federal district court recently upheld the law, relying on *United Wire*'s rejection of the economic impact standard. However, if this Court embraces the *Travelers* standard, the New Jersey plan, like so many other state efforts, will succumb to ERISA preemption.

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impact standard of ERISA preemption is any less flawed as regards self-insured plans.

C. Even State Health Care Laws With A *De Minimis* Effect On ERISA Plans May Be Preempted Under Travelers.

The indirect economic impact test established in the *Travelers* decision also creates an unavoidable "slippery slope." If any state law with an indirect economic effect on ERISA plans is preempted, all state laws regulating health care services are at risk of preemption. States cannot possibly address even the basic regulation of health care, let alone health care reform, if state health care laws that may result in health care facilities increasing their charges to patients are preempted. Because of the way some lower courts have applied *Travelers*, all state laws that are in the health care field could be preempted. *See NYSA-ILA*, 27 F.3d at 827 (uniform assessment of 0.6% on health care facilities preempted because ERISA plans operate in the health care arena).

The result is that the quality of care provided by medical facilities is at risk as a consequence of the *Travelers* decision. States assume responsibility for providing their residents with quality medical care. For example, most, if not all, states maintain extensive licensing laws that require health care facilities to meet minimum standards for ratios of patients to registered nurses, infection control activities, sanitary conditions, dietary and laundry services, maintenance of medical records, etc. *See, e.g.*, Cal. Health and Safety Code § 1254 (Deering Supp. 1994); Ill. Ann. Stat. ch. 210, para. 85/1 *et seq.* (1993) (Hospital Licensing Act); S.C. Code Ann. § 44-7-250 (Law. Co-op. Supp. 1993). States also impose vigorous standards concerning the disposal of medical waste to protect both patients and the general public from unsanitary and dangerous conditions. *See, e.g.*, Cal. Health and Safety Code § 25015 *et seq.* (West Supp. 1994) (Medical Waste

Management Act); Fla. Stat. Ann. § 381.0098, *et seq.* (1993 and Supp. 1994); R.I. Gen. Laws § 23-19.12-1 *et seq.* (Supp 1993); S.C. Code Ann. § 44-93-10 *et seq.* (Law. Co-op. Supp. 1993) (South Carolina Infectious Waste Management Act).

All of these regulations carry a price tag for medical providers. Under the *Travelers* test, these provisions could be preempted. Health care facilities typically include their costs of compliance in charges to patients, and many patients are ERISA plan participants and beneficiaries. The absurd result, therefore, is that states will not be permitted to protect the public health.

Both the Third Circuit and the federal district court in Minnesota have recognized that such a result is untenable. *See United Wire*, 995 F.2d at 1194; *Boyle*, 849 F. Supp. at 1313-17. In both of these decisions, the courts rejected the legal argument that indirect economic impact alone, absent other factors that interfere with the operation of ERISA plans, is sufficient to preempt state health care statutes.

If this Court allows the *Travelers* economic impact standard to be applied to state laws that apply uniformly to health care providers and/or patients regardless of their ERISA status, it is difficult to conceive of any state laws aimed at health care regulation and reform that could withstand an ERISA challenge. This Court must preserve states' authority to regulate their health care systems, consistent with both legislative intent and common sense. Congress did not intend to strip the states of their authority to regulate health care and institute health care reform. Certainly, in the absence of federal regulation, states must be permitted to continue their efforts to

preserve the quality of health care and reduce the substantial number of their citizens who are without access to necessary health care.[12]

D. The Indirect Economic Impact Standard Is Likely To Affect Other Areas Of State Regulation.

ERISA plans provide benefits in other areas besides health care, including education, day care and legal services. State regulation in each of these fields inevitably costs ERISA plans, like everyone else, more than they would otherwise pay for those services. For example, in the day care field, building codes and staffing ratios that seek to ensure the safety of the children and the quality of the program unquestionably increase costs. Under the *Travelers* indirect economic impact standard, states conceivably could be preempted from imposing such quality and safety requirements. Moreover, if an employer or union runs a day care program directly through an ERISA-covered plan, conceivably the Second Circuit, following its decision in *NYSA-ILA*, would hold that the economic impact need not even be substantial to warrant ERISA preemption. Once again the charmed existence

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[12] In 1992, 17.4% of the nonelderly population – 38.5 million people – were not covered by private health insurance and did not receive publicly financed health assistance. This figure represents an increase of 0.8% over 1991 figures (36.3 million people).

In 12 states and the District of Columbia, more than 20% of the population was uninsured in 1992. These states and their uninsured rates were Nevada (26.6%), Oklahoma (25.8%), Louisiana (25.7%), Texas (25.7%), the District of Columbia (25.5%), Florida (24.2%), Arkansas (23.5%), Mississippi (22.7%), New Mexico (22.5%), Georgia (22.4%), California (22.2%), South Carolina (20.8%) and Alabama (20.1%). *See EBRI Issue Brief, supra*, at 1.

created by the economic impact standard would have a consequence that exceeds both congressional intent and common sense.

E. Should The Court Reach A Decision In This Case That The Surcharges Are Preempted Or Are Otherwise Inappropriate, Such Decision Should Not Extend Beyond The Facts Of The Case.

Like New York, other states have engaged in hospital rate-setting activity. Unlike New York, however, whose surcharges treated patients differently based on the identity of the insurer, other states, such as Maryland, for example, do not impose any surcharges.[13] In Maryland, approved rate structures are comprised of various cost elements, and charges are applied uniformly among all payors, including Medicare and Medicaid. In Connecticut, under the Uncompensated Care Pool statute, the costs of uncompensated care were spread more equitably among the state's hospitals. The system taxed all patients the same amount and taxed hospitals on the revenue they received from all patients. It did not differentiate in any way on the basis of the type of insurance coverage that was involved. Similarly, Massachusetts' uncompensated

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[13] The New York surcharges were designed to "level the playing field for the Blues in their competition with commercial insurers." *Travelers*, 14 F.3d at 712. Thus, the Second Circuit noted that the New York surcharges had a "connection with" ERISA plans because they were intended to influence the choices that ERISA plans made for health care coverage by increasing the costs of the less favored alternatives. *Id.* at 719. The court's indirect economic impact standard does not appear to be dependent on this factor. To the extent the Court believes this factor is determinative of the case, the decision should be narrowly limited to similar circumstances of differential treatment.

care pool spreads the costs of uncompensated care more equitably among its hospitals without differentiating on the basis of insurance coverage.

Because hospital rate-setting programs across the country differ significantly from the New York surcharges, and because many states are engaging in other forms of properly authorized health care-related activities on behalf of their citizens, it is respectfully requested that if a decision herein invalidates the surcharges, such decision not be so broad-based as to extend beyond the characteristics presented solely by the New York system.[14]

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[14] The Court should also note that in *Travelers*, the Court of Appeals concluded that the three surcharges imposed a "significant economic burden" based solely on an examination of the surcharges standing alone and not on an analysis of the overall impact of the regulatory scheme in New York. Because hospital rate-setting comprises consideration of many elements, it is not reasonable, or even possible, to evaluate the net effect of a hospital rate-setting system solely on the basis of one element of that system.

The State of Maryland, for example, provides a good example of why a rate system should be evaluated as a whole to arrive at its net impact on ERISA plans. Before hospital regulation in Maryland, Blue Cross plans were the beneficiaries of an approximately 14% discount. Today, under rate regulation, Blue Cross (and any other insurer or HMO that satisfies certain criteria) receives a 4% discount from rates that have been certified as reasonable. Further, although the Maryland system, like others, includes various elements, taken as a whole, hospital costs per admission in Maryland have moved from a level of 25% above the national average in 1976 to a level of 11% below the national average in 1993. As a result of lower than average costs and lower than average mark-up of charges over costs, charges per case in Maryland were less than 64% of the average charges nationally per case in 1992, the last year for which data were available. American Hospital Association, *Hospital Statistics* (1993-94 ed.)

CONCLUSION

ERISA's preemption provision was not intended to eviscerate our principles of federalism. "ERISA pre-emption analysis 'must be guided by respect for the separate spheres of governmental authority preserved in our federalist system.' " *Fort Halifax Packing Co.*, 482 U.S. at 19 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981)). "We also must presume that Congress did not intend to pre-empt areas of traditional state regulation." *Metropolitan Life Ins. Co., Inc. v. Massachusetts*, 471 U.S. 724, 740 (1985). Thus, the well-established presumption against preemption that ensures the proper respect for federalism concerns is applicable even in ERISA preemption analysis, and particularly so where, as here, a traditional area of state regulation such as health care is involved. The Second Circuit's indirect economic impact standard for ERISA preemption fails to give these principles their due.

For the foregoing reasons, indirect economic impact alone should be rejected as a basis for ERISA preemption, and the decision of the Second Circuit Court of Appeals should be reversed.

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